Technical Brief
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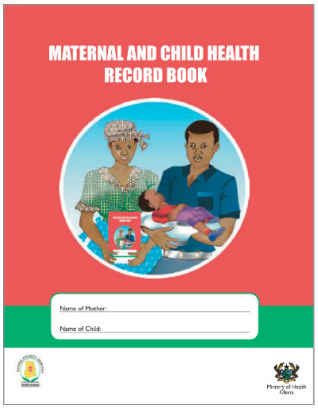
GHANA: Enhancing the potential of Ghana's MCH Handbook through the implementation of completion checklists in a tertiary hospital



Maternal and Child Health Record Book, Ghana, 2023

Background

As a home-based record for mothers, newborns, and children, the Maternal and Child Health Record Book (MCH RB) provides crucial information to promote and sustain family health. Its primary goal is to advance maternal, newborn, and child health (MNCH) by ensuring a seamless continuum of care. In Ghana, pregnant women receive the book when they attend antenatal care for the first time, and they use it throughout their pregnancy at all healthcare facilities. It is relied upon critically during labor, enabling skilled birth attendants to access the key information required for a safe delivery. In addition to establishing the link between maternal and newborn health, the book is useful throughout the entire postnatal phase and covers the child's first five years of life.

The current system in Ghana is a significant improvement over the previous system. Before 2017, the country relied on two separate books, one for maternal health and one for child health. This meant that, after birth and the puerperium, the maternal book was set aside, and the child book was introduced. This resulted in a discontinuity that hindered healthcare providers' ability to access a complete patient history, thereby compromising holistic care for children. Recognizing this issue, the Ministry of Health and the Ghana Health Service, supported by Japan International Cooperation Agency (JICA), introduced the combined MCH RB in 2017. Since then, this unified information and record has delivered extensive benefits to mothers, children, and health workers at all levels, effectively functioning as an essential tool for communication, referral, and health education, and ultimately empowering mothers.

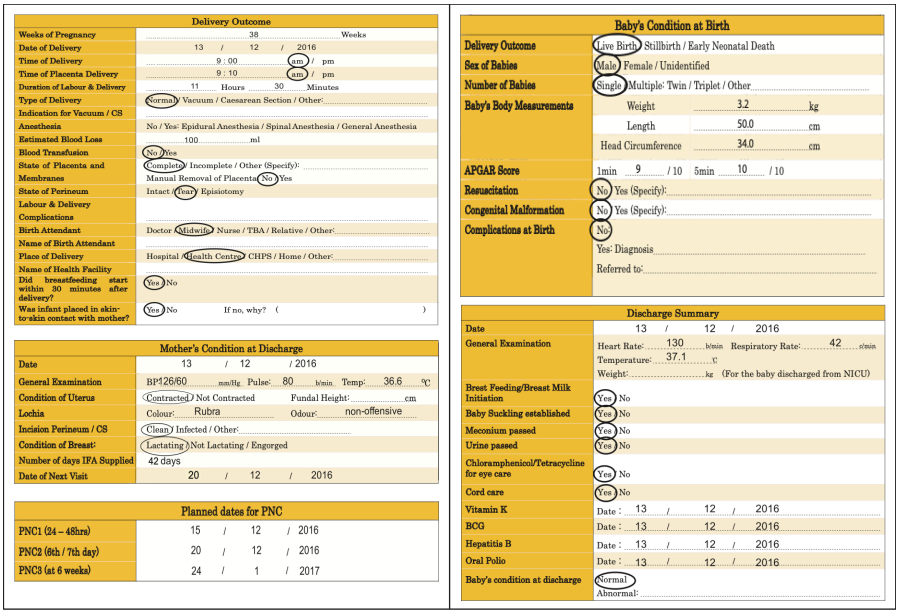
Challenges to care integration

The MCH RB is used in all public and private healthcare facilities in Ghana. Its effectiveness as an integration tool depends critically on care providers, particularly midwives, understanding its key functions, since they are the first to handle it. Before a pregnant woman transitions to a child health clinic, the antenatal care, delivery, and postnatal care sections must be fully documented. Incomplete records severely undermine the book's effectiveness. Its ability to integrate care and facilitate referrals becomes fractured. This lack of continuity ultimately reduces staff efficiency and wastes limited resources by necessitating the duplication of interventions during follow-up care.

Delivery records found on pages 21 and 22 of Ghana's MCH RB are crucial for ensuring seamless continuity of care for mothers and children after discharge (Figure 1). Completing these two pages is the first step in achieving the aim of linking maternal and child health records. However, these two pages are at risk of remaining incomplete, as the labor and postnatal wards are often busy. While participating in JICA's 2023 Knowledge Co-Creation Program on the Continuum of Care for MNCH and Universal Health Coverage held in Japan, one of the authors developed an action plan to address this issue.

Implementation and evaluation of the action plan

An initial survey was conducted in March 2024 at the Korle Bu Teaching Hospital, aimed at determining the completion rate for pages 21 and 22. Implementation of an audit tool within routine postnatal clinics (Monday–Friday) facilitated the systematic verification of birth/delivery data recorded in clients' handbooks. Trained midwives confirmed the completeness of data during each



Delivery Outcome

Weeks of Pregnancy	38 Weeks
Date of Delivery	13 / 12 / 2016
Time of Delivery	9 : 00 (am) / pm
Time of Placenta Delivery	9 : 10 (am) / pm
Duration of Labour & Delivery	11 Hours 30 Minutes
Type of Delivery	(Normal) / Vacuum / Caesarean Section / Other:
Indication for Vacuum / CS	
Anesthesia	No / Yes: Epidural Anesthesia / Spinal Anesthesia / General Anesthesia
Estimated Blood Loss	100 ml
Blood Transfusion	(No) Yes
State of Placenta and Membranes	(Complete) Incomplete / Other (Specify): Manual Removal of Placenta (No) Yes
State of Perineum	Intact (Tear) Episiotomy
Labour & Delivery Complications	
Birth Attendant	Doctor (Midwife) Nurse / TBA / Relative / Other:
Name of Birth Attendant	
Place of Delivery	Hospital (Health Centre) CHPS / Home / Other:
Name of Health Facility	
Did breastfeeding start within 30 minutes after delivery?	(Yes) No
Was infant placed in skin-to-skin contact with mother?	(Yes) No If no, why? ( )

Mother's Condition at Discharge

Date	13 / 12 / 2016
General Examination	BP 126/60 mm/Hg Pulse: 80 b/min Temp: 36.6 °C
Condition of Uterus	(Contracted) Not Contracted Fundal Height: cm
Lochia	Colour: Rubra Odour: non-offensive
Incision Perineum / CS	(Clean) Infected / Other:
Condition of Breast:	(Lactating) Not Lactating / Engorged
Number of days IFA Supplied	42 days
Date of Next Visit	20 / 12 / 2016

Planned dates for PNC

PNC1 (24 – 48hrs)	15 / 12 / 2016
PNC2 (6th / 7th day)	20 / 12 / 2016
PNC3 (at 6 weeks)	24 / 1 / 2017

Baby's Condition at Birth

Delivery Outcome	(Live Birth) Stillbirth / Early Neonatal Death
Sex of Babies	(Male) Female / Unidentified
Number of Babies	(Single) Multiple: Twin / Triplet / Other
Baby's Body Measurements	Weight 3.2 kg; Length 50.0 cm; Head Circumference 34.0 cm
APGAR Score	1min 9 / 10 5min 10 / 10
Resuscitation	(No) Yes (Specify):
Congenital Malformation	(No) Yes (Specify):
Complications at Birth	(No) Yes: Diagnosis Referred to:

Discharge Summary

Date	13 / 12 / 2016
General Examination	Heart Rate: 130 b/min Respiratory Rate: 42 e/min Temperature: 37.1 °C Weight: kg (For the baby discharged from NICU)
Breast Feeding/Breast Milk Initiation	(Yes) No
Baby Suckling established	(Yes) No
Meconium passed	(Yes) No
Urine passed	(Yes) No
Chloramphenicol/Tetracycline for eye care	(Yes) No
Cord care	(Yes) No
Vitamin K	Date : 13 / 12 / 2016
BCG	Date : 13 / 12 / 2016
Hepatitis B	Date : 13 / 12 / 2016
Oral Polio	Date : 13 / 12 / 2016
Baby's condition at discharge	(Normal) Abnormal:

▲ **Figure 1. Recording format on pages 21 and 22 of MCH RB, including examples**

The MCH RB completion checklist at the admission and delivery desk of the labor ward.

consultation. They also examined the issue of staff roles and task sharing when completing the MCH RB in large centers, such as tertiary facilities with multiple care providers. Upon assessing a sample of 113 MCH RB records, it was found that documentation of the critical delivery records on pages 21 and 22 was highly inconsistent. Fewer than one-third of the records were fully complete, with only 13.3% having both pages completely filled. The majority of the records (59.5%) were only partially completed, particularly the mode of delivery, birthweight, APGAR scores, whether any complication occurred at delivery, and whether breastfeeding was initiated within 30 minutes after birth. A significant proportion of 27.2% had completely blank delivery pages.

One major reason given by midwives for these low fill-out rates was that there were multiple documents, in addition to the MCH RB, that needed to be completed. These findings led to a significant quality improvement effort in the hospital. The maternity unit initiated comprehensive staff training to emphasize the function of the MCH RB as a communication and referral tool in MNCH. The MCH RB was also incorporated into all maternity unit orientations for new staff as a mandatory discussion topic. To standardize documentation, completion checklists were developed and implemented in December 2024 to ensure the completion of specific content, including pages 21 and 22. These checklists are now used in labor and delivery wards, postnatal wards, and postnatal clinics (Figure 2). They aim to remind busy care providers of the importance of the book and facilitate the re-education of new mothers on its contents.

To measure the intervention's impact, an evaluation of the completion rate was subsequently conducted from 1st August 2025 to 29th September 2025. A total of 1,013 MCH RBs were assessed on page 21 for completion, and 1,033 on page 22. The data shows that the documentation rate was notably high for both pages. Specifically, 90.2% of the assessed books (n = 912) had page 21 fully completed, with only 9.8% (n = 101) remaining blank. Similarly, 90.2% of the assessed books (n = 932) had page 22 fully completed, while 9.8% (n = 101) were incomplete. This indicates a high level of compliance for completing critical intrapartum records on both pages of the MCH RB.

Assessing the completion rates of these two pages after the intervention revealed an almost complete reversal of the situation before the intervention. This may be partly due to the initial and sustained awareness of the importance of these two pages for continuity of care, as well as the presence of the completion checklists to remind midwives.

Conclusion

The maternity unit of Ghana's largest teaching hospital was able to significantly increase the completion rate of the MCH RB by implementing in-service training and incorporating MCH RB protocols into new staff orientation. The introduction of a completion checklist was a vital first step, providing a much-needed reminder for staff working in busy units like labor and delivery. Over time, it was observed that the mere visibility of these checklists ensured that healthcare workers maintained better compliance with MCH RB documentation.

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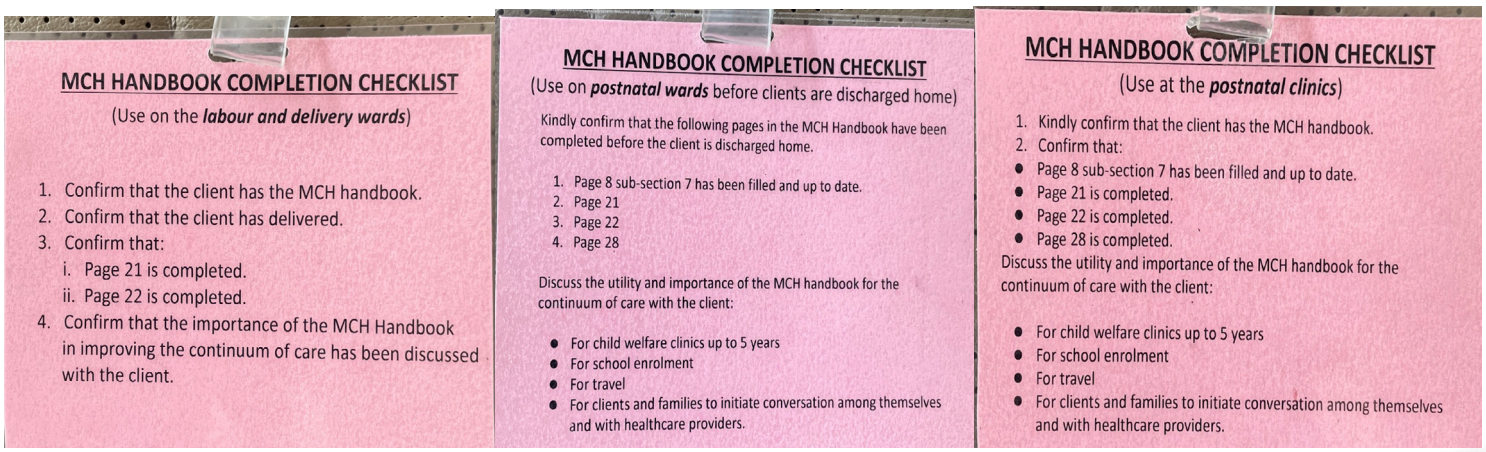
Further readings:

1. Carandang RR, et al. Roles of the maternal and child health handbook and other home-based records on newborn and child health: a systematic review. *Int J Environ Res Public Health*. 2021 Jul 13; **18** (14): 7463.
2. Osaki K, Aiga H. Adapting home-based records for maternal and child health to users' capacities. *Bull World Health Organ*. 2019 Feb 14; **97** (4): 296–305.



▲ **Figure 2. Sample of MCH RB completion checklists**